



Child and Adult Care Food Program  
**CHILD ENROLLMENT FORM**

Provider Name: \_\_\_\_\_

**Note to Parents/Guardians:** Your child(ren) is enrolled for care at a day care facility that participates in the Child and Adult Care Food Program (CACFP). By participating in this program, the day care facility is serving a variety of nutritious foods to your child(ren) and receiving reimbursement to assist with food costs. To meet program requirements, the day care facility is required to have parent's complete enrollment information annually for each child enrolled for care. This form will be placed in our files and treated as confidential information.

Last Name, First Name	Date of Birth	Times of Care		Regular Days of Care							Meals Served During Care					Ethnic/Race*		
		Arrival Time	Leave Time	M	T	W	TH	F	S	S	Br	AM Sn	Lu	PM Sn	Dn	Ev Sn	Ethnicity	Race

\* **Ethnicity** (Select one and enter in chart above): **H**=Hispanic or Latino or **N**=Not Hispanic or Latino

\* **Race** (Select one and enter in chart above): **W**=White, **B**=Black or African American, **I**=American Indian or Alaskan Native, **A**=Asian, or **P**=Native Hawaiian or Other Pacific Islander

Does the child(ren) regularly attend another program (preschool, school, etc.)? \_\_\_ Yes or \_\_\_ No

Does the child(ren)'s schedule vary? \_\_\_ Generally Not \_\_\_ Frequently \_\_\_ Drop In Care

If yes, list name, circle days and list time not in care at this home:

Child's Name: \_\_\_\_\_ M T W T F S S

Time Leave: \_\_\_\_\_ Time Return: \_\_\_\_\_

Child's Name: \_\_\_\_\_ M T W T F S S

Time Leave: \_\_\_\_\_ Time Return: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Cell or Home: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Complete this section only if your child is under 1 year*

**FORMULA offered by the provider:** Name of formula \_\_\_\_\_

**SOLIDS: check one**

I accept the provider's food when my infant is developmentally ready.

I decline and will provide the solid foods for my infant.

I accept the provider's formula

I decline the provider's formula and will provide \_\_\_\_\_

I will supply breastmilk

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(1) Mail: U.S. Department of Agriculture  
 Office of the Assistant Secretary for Civil Rights  
 1400 Independence Avenue, SW  
 Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

This institution is an equal opportunity provider.

(3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).